

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0014753</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>TWIN WILLOWS NURSING CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-01</u> to <u>12-31-01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>Box 370</u> <u>Salem</u> <u>62881</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Marion</u>		Officer or Administrator of Provider (Signed) <u>3-30-02</u> (Type or Print Name) <u>Todd Curtis Woodruff</u> (Date)	
Telephone Number: <u>(618) 548-0542</u> Fax # <u>(618) 548-5893</u>		(Title) <u>Administrator</u>	
IDPA ID Number: <u>37-098-7942001</u>		(Signed) _____ (Date)	
Date of Initial License for Current Owners: <u>5/2/73</u>		Paid Preparer (Print Name and Title) _____	
Type of Ownership:		(Firm Name & Address) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Todd Woodruff</u> Telephone Number: <u>(618) 548-0542</u>			

Facility Name & ID Number TWIN WILLOWS NURSING CENTER# 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds76

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,740</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>15,891</u>	<u>4,564</u>		<u>20,455</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,891</u>	<u>4,564</u>		<u>20,455</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.74%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/10/73

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: 01/01/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	110,079	15,603	4,377	130,059		130,059		130,059		1
2	Food Purchase		134,803		134,803		134,803	(149)	134,654		2
3	Housekeeping	50,102	11,353		61,455		61,455		61,455		3
4	Laundry	25,455	6,687		32,142		32,142		32,142		4
5	Heat and Other Utilities			49,105	49,105		49,105	(960)	48,145		5
6	Maintenance	24,059	12,819	14,742	51,620		51,620		51,620		6
7	Other (specify):*										7
8	TOTAL General Services	209,695	181,265	68,224	459,184		459,184	(1,109)	458,075		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	559,684	33,998	6,787	600,469		600,469		600,469		10
10a	Therapy										10a
11	Activities	34,268	3,747		38,015		38,015		38,015		11
12	Social Services	14,071		2,771	16,842		16,842		16,842		12
13	Nurse Aide Training	11,303	938	4,023	16,264		16,264		16,264		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	619,326	38,683	13,581	671,590		671,590		671,590		16
	C. General Administration										
17	Administrative	45,000			45,000		45,000		45,000		17
18	Directors Fees										18
19	Professional Services			42,339	42,339		42,339	(17,700)	24,639		19
20	Dues, Fees, Subscriptions & Promotions			5,976	5,976		5,976		5,976		20
21	Clerical & General Office Expenses		10,754	4,727	15,481		15,481		15,481		21
22	Employee Benefits & Payroll Taxes			125,406	125,406		125,406		125,406		22
23	Inservice Training & Education										23
24	Travel and Seminar			962	962		962		962		24
25	Other Admin. Staff Transportation			1,206	1,206		1,206		1,206		25
26	Insurance-Prop.Liab.Malpractice			34,141	34,141		34,141		34,141		26
27	Other (specify):*										27
28	TOTAL General Administration	45,000	10,754	214,757	270,511		270,511	(17,700)	252,811		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	874,021	230,702	296,562	1,401,285		1,401,285	(18,809)	1,382,476		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**

#0014753

Report Period Beginning:

01-01-01

Ending:

12-31-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			32,713	32,713		32,713		32,713			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,175	22,175		22,175	(22,175)				32
33	Real Estate Taxes			25,759	25,759		25,759		25,759			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rent Storg Space			1,200	1,200		1,200		1,200			36
37	TOTAL Ownership			81,847	81,847		81,847	(22,175)	59,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		9,271		9,271		9,271		9,271			41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		9,271	41,610	50,881		50,881		50,881			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	874,021	239,973	420,019	1,534,013		1,534,013	(40,984)	1,493,029			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

0014753

Report Period Beginning: 01-01-01

Ending: 12-31-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms	(960)	5-7	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income	(22,175)	32-7	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(149)	2-7	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers	(17,700)	19-7	22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,984)		30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (40,984)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

TWIN WILLOWS NURSING CENTERID# 0014753Report Period Beginning: 01-01-01Ending: 12-31-01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12-31-01

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Helen Woodruff	95			Motel Developments	Salem	Motel
Jeffrey Woodruff	5			Woodruff Services	Carbondale	Air Cond/Heating

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V	11 Flower for resident Xmas	320	Jeffery Woodruff	5.00%	320	
3	V	36 Office Storage	1,200	Motel Developments	100.00%	1,200	
4	V	32 Interest	16,776	Todd Woodruff	0.00%	16,776	
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 18,296			\$ 18,296	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Todd Woodruff	Administrator	Management	0.00		60	100.00	Interest	\$ 16,776	32	1
2	Todd Woodruff	Administrator	Management	0.00		60	100.00	Salary	45,000	17	2
3	Helen Woodruff	Audit Accounting	Audit Accounting	95.00		20	30.00	Fees	23,500	19	3
4	Hubert Woodruff	Attorney	Legal Mgmt	0.00		5	10.00	Fees	17,700	19	4
5	Jeffrey Woodruff	Woodruff Services	Heating/Air	5.00				Sale of	320	11	5
6								Flowers			6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 103,296		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Bonds			Working Capital			\$ 8,000	\$ 8,000	12-31-84	10.0000	\$ 800	1							
2	Bonds			Purchase Factory		11-2-72	36,450	5,150	12-31-84	10.0000	515	2							
3	Todd Woodruff			Working Capital		1-87	191,726	208,502	12-31-02	8.7500	16,776	3							
4	Bank of Christopher			Working Capital	\$3,450.00	10-23-96	290,000		9-23-02	9.7500	131	4							
5												5							
	Working Capital																		
6	Finance Charges										942	6							
7	Accounts Payable											7							
8												8							
9	TOTAL Facility Related				\$3,450.00		\$ 526,176	\$ 221,652			\$ 19,164	9							
	B. Non-Facility Related*																		
10	See original document			Purchase Office Bldg	\$3,577.00	4-1-86	195,455	21,509	12-31-93	14.0000	3,011	10							
11				216 S. Broadway								11							
12												12							
13												13							
14	TOTAL Non-Facility Related				\$3,577.00		\$ 195,455	\$ 21,509			\$ 3,011	14							
15	TOTALS (line 9+line14)						\$ 721,631	\$ 243,161			\$ 22,175	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**# **0014753** Report Period Beginning: **01-01-01** Ending: **12-31-01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																		
1. Real Estate Tax accrual used on 2000 report.		\$ 24,723	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 24,716	2															
3. Under or (over) accrual (line 2 minus line 1).		\$ (7)	3															
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 25,759	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 25,759	7															
Real Estate Tax History:																		
Real Estate Tax Bill for Calendar Year:	1996 19,053 8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																		
13	FROM R. E. TAX STATEMENT FOR 2000 \$			13														
14	PLUS APPEAL COST FROM LINE 5 \$			14														
15	LESS REFUND FROM LINE 6 \$			15														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																
	1997 20,373 9																	
	1998 22,623 10																	
	1999 23,673 11																	
	2000 24,716 12																	
2001 based on amount of increase in tax paid from 99-2000 added to 2000 tax for 2001 real estate tax																		

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TWIN WILLOWS NURSING CENTER COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT Todd Woodruff

TELEPHONE (618) 548-0542 FAX #: (618) 548-5893

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-02-000-027</u>	<u>PT SE NE</u>	\$ <u>24,716.20</u>	\$ <u>24,716.20</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,716.20</u>	\$ <u>24,716.20</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

16,205

B. General Construction Type:

Exterior

Brick

Frame

Fireproof Construct

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	87,000	1973	\$ 28,000	1
2					2
3	TOTALS	87,000		\$ 28,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1973	1966	\$ 380,183	\$ 11,406	33 1/3	\$ 11,406		\$ 330,774	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											9
11											10
12	Roof			1976	27,500		10				11
13	Water Heater			1977	1,024		10			1,024	12
14	Fire Exit Lights			1978	695		5			695	13
15	Emergency Power			1978	1,695		5			1,695	14
16	Emergency Power			1979	1,359		5			1,359	15
17	Compressor			1979	372		5			372	16
18	Battery Units			1980	570		3			570	17
19	Compressor			1980	533		5			533	18
20	Mixing Valve			1981	780		10			780	19
21	Central Air			1981	771		10			771	20
22	Disposal Kitchen			1982	745		10			745	21
23	Storage Shed			1982	600		8			600	22
24	3 Heat Pumps			1983	2,245		10			2,245	23
25	Phone System			1985	3,318		20			3,318	24
26	2 Heat Pumps			1985	1,400		8			1,400	25
27	Driveway			1988	2,767		3			2,767	26
28	Seal Coat/Patch Driveway			1997	1,850		3			1,850	27
29	Door Monitor System			1999	7,590		10	759	759	1,708	28
30	3 Central Air System - 3 ton			1999	12,588		5	2,518	2,518	5,350	29
31	Replacement Roof			1999	64,580		15	4,305	4,305	8,969	30
32	Asphalt Top Coat Driveway			1999	16,136		8	2,017	2,017	4,286	31
33	Outside Walkway Lights			1999	600		5	120	120	295	32
34	Replace South Wing Sewer Line			2000	1,046		10	105	105	166	33
35	Replace Three Outside Hydrants			2000	525		10	52	52	56	34
36											35

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

01-01-01 Ending: 12-31-01

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 94,922	\$ 11,230	\$ 11,230			\$ 11,230	71
72	Current Year Purchases	2,578	201	201		8	201	72
73	Fully Depreciated Assets	79,445					79,445	73
74								74
75	TOTALS	\$ 176,945	\$ 11,431	\$ 11,431	\$		\$ 90,876	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Wagon 87	1987	\$ 10,990	\$	\$		4	\$ 10,990	76
77										77
78										78
79										79
80	TOTALS			\$ 10,990	\$	\$			\$ 10,990	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 719,841	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,713	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,713	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 514,668	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Alumelite Trailer	\$ 10,000	\$	\$ 10,000	86
87	216 S Broadway	56,000		56,000	87
88	Schedule	19,807	501	11,061	88
89	Driveway 216	6,520	652	818	89
90					90
91	TOTALS	\$ 92,327	\$ 1,153	\$ 77,879	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Motel Developments-Rents Office/Storage Space**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 1,200			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 1,200			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning **01-01-01**

Ending **12-31-01**

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2002** \$ **1,200**

13. **/2003** \$

14. **/2004** \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER AIDE _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 287	\$ 3,186	\$	\$ 3,473
2	Books and Supplies	91	847		938
3	Classroom Wages (a)	202	8,841		9,043
4	Clinical Wages (b)	50	2,210		2,260
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	\$ 630	\$ 15,634	\$	\$ 16,264
10	SUM OF line 9, col. 1 and 2 (e)	\$ 16,264			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	11

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10-3	hrs		6	412		6	412	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10-3	hrs		6	600		6	600	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	12	\$ 1,012	\$	12	\$ 1,012	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 280,064	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	355,482		3
4	Supply Inventory (priced at)	12,500		4
5	Short-Term Investments	11,691		5
6	Prepaid Insurance	27,000		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,000		8
9	Other(specify): 1120 Tax Deposits	38,650		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 841,387	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	40,100		11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	436,183		14
15	Leasehold Improvements, at Historical Cost	88,807		15
16	Equipment, at Historical Cost	255,722		16
17	Accumulated Depreciation (book methods)	514,668		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 338,144	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,179,531	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,350	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,200		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,900		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,759		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,995		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 146,204	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	387,424		39
40	Mortgage Payable			40
41	Bonds Payable	13,150		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Stock	3,500		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 404,074	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 550,278	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 629,253	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,179,531	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 549,981	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 549,981	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	13,375	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Adjusting Balance Sheet	65,897	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 79,272	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 629,253	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,540,270	1
2	Discounts and Allowances for all Levels	(5,709)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,534,561	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	10,856	11
12	Gift and Coffee Shop	7,439	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,323	14
15	Telephone, Television and Radio	466	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	162	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,246	23
	D. Non-Operating Revenue		
24	Contributions	222	24
25	Interest and Other Investment Income***	17,407	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,629	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	216 Rental	7,200	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,200	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,579,636	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	458,075	31
32	Health Care	671,590	32
33	General Administration	252,811	33
	B. Capital Expense		
34	Ownership	59,672	34
	C. Ancillary Expense		
35	Special Cost Centers	9,271	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,493,029	40
41	Income before Income Taxes (line 30 minus line 40)**	86,607	41
42	Income Taxes	3,995	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 13,375	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**# **0014753**Report Period Beginning: **01-01-01**

Ending:

12-31-01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	2,080	2,226	\$ 45,350	\$ 20.37	1
2					2
3	6,776	7,141	112,106	15.69	3
4	7,331	8,312	105,624	12.70	4
5	41,403	42,877	283,497	6.61	5
6	2,078	2,078	11,303	5.44	6
7					7
8					8
9	1,568	1,776	12,051	6.79	9
10	3,453	3,668	22,217	6.06	10
11	1,807	1,897	14,071	7.42	11
12					12
13					13
14	2,978	3,180	26,407	8.30	14
15	7,078	7,163	46,020	6.42	15
16	5,861	6,298	37,652	5.98	16
17	1,935	2,282	24,059	10.54	17
18	7,831	8,279	50,102	6.05	18
19	3,624	4,038	25,455	6.30	19
20	3,000	3,040	45,000	14.80	20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31	1,784	1,917	13,107	6.84	31
32					32
33					33
34	100,587	106,172	\$ 874,021 *	\$ 8.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	110	\$ 4,377	1-3	35
36				36
37				37
38				38
39	36	975	10-3	39
40	36	3,600	10-3	40
41				41
42				42
43				43
44				44
45	49	2,771	12-3	45
46				46
47	12	1,200	10-3	47
48				48
49	243	\$ 12,923		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$4,131
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,998 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,610
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? Less than 1
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.